

FILED AUG 11 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

24399

State File No.

318

PRIMARY REG. DIST. NO. 1003 Registrar's No. 7154

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. 7154			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>St. Louis</u>)		c. LENGTH OF STAY (in this place) <u>48hrs</u>		c. CITY OR TOWN <u>St. Louis</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Missouri Baptist Hospital</u>				e. STREET ADDRESS (If rural, give location) <u>12 5455 Delmar</u> <u>2129</u>					
3. NAME OF DECEASED (Type or Print) a. (First) <u>Edward</u>		b. (Middle) <u>L.</u>		c. (Last) <u>Cooley</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Aug. 1, 1954</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>April 21, 1863</u>			
9. AGE (in years last birthday) <u>91yrs</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 HRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Physician</u>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <u>Truro, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13a. FATHER'S NAME <u>Unknown</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>			14. NAME OF HUSBAND OR WIFE <u>Mrs. Mabel Cooley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknowns) <u>yes</u>		16. SOCIAL SECURITY NO. <u>493-24-2337</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Mabel Cooley</u>				ADDRESS <u>5455 Delmar</u>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Terminal Pneumonia</u> ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Arteriosclerosis</u> II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 days</u> <u>years</u>	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>4201</u>					
22. I hereby certify that I attended the deceased from <u>July 24, 1954</u> , to <u>Aug 1, 1954</u> , that I last saw the deceased alive on <u>Aug 1, 1954</u> , and that death occurred at <u>2:30P.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE <u>Ray Avalon Sr.</u>			23b. ADDRESS <u>Overton 14 Mo</u>			23c. DATE SIGNED <u>8-2-54</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		24b. DATE <u>Aug. 3, 1954</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Crematory</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis Co., Mo.</u>			
DATE RECD BY LOCAL REG. <u>AUG 2 1954</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>			25. FUNERAL DIRECTOR'S SIGNATURE <u>W. G. Alexander & Sons 6175 Delmar</u>				
					ADDRESS <u>6175 Delmar</u>				

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

(Licensed Embalmer's Statement on Reverse Side)

Dr R. G. Walther
2438 Woodson Rd
Wilb-0256

Harrison 9-0256

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Jos. E. McCulloch*.....

Licensed Embalmer No. 299
P. O. Address 61508

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.